DEPARTMENT OF ECONOMIC SECURITY,
COMPREHENSIVE MEDICAL AND DENTAL PROGRAM

COMPREHENSIVE MEDICAL & DENTAL PROGRAM

PROVIDER REVIEW

Volume 7, Issue 2

JUNE 2007

Do You Have Your National Provider Identifier? Getting an NPI is free - not having one can be costly!

National Provider Identifier (NPI)

It's every provider's responsibility to make sure that an NPI is obtained if the provider is required to do so. If you're not sure, it's time to investigate. Get your NPI now so you have time to prepare before the compliance date. This includes sharing your NPI and appropriately testing it with payers to avoid a disruption in cash flow. Healthcare providers can still apply for National Provider Identifiers (NPI) in one of three ways.

1. For the most efficient application processing and the fastest receipt of NPIs, healthcare providers should consider using the web-based NPI application process. They can log onto the National Plan and Provider Enumeration System (NPPES) and apply online at https://nppes.cms.hhs.gov/NPPES/Welcome.do; or

2. Healthcare providers can agree to have an Electronic File Interchange (EFI) organization (EFIO) submit application data on their behalf (i.e., through a bulk enumeration process) if an EFIO requests their permission to do so; or,

3. Healthcare providers may wish to obtain a copy of the paper NPI Application/Update Form (CMS-10114) and mail the completed, signed application to the NPI Enumerator located in Fargo, ND, whereby staff at the NPI Enumerator will enter the application data into NPPES. The form will be available only upon request through the NPI Enumerator. Healthcare providers who wish to obtain a copy of this form must contact the NPI Enumerator in any of these ways:

Phone: 1-800-465-3203 or TTY1-800-692-2326
E-mail: customerservice@npienumerator.com

Mail: NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059

NPI Training Package

CMS has developed a training package on NPI that will assist providers with self-education, as well as education of staff. This package is also useful to national and local medical societies for group presentations and training. The entire package will consist of five modules: General Information, Electronic File Interchange (EFI), Subparts, Data Dissemination and Medicare Implementation. Each Module consists of a PowerPoint presentation (with speaker's notes) and is designed to stand alone or can be combined with other Modules for a training session tailored to the particular audience.

Modules will be posted to the CMS NPI web page as completed.

Modules currently available include:

- Module 1: General Information
- Module 2: Electronic File Interchange (EFI)
- Module 3: Subparts

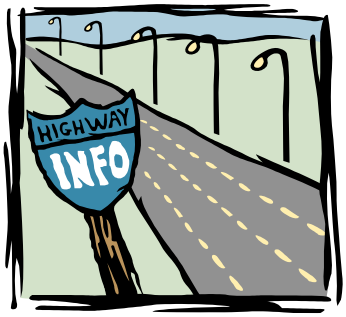
To view these Modules, visit http://www.cms.hhs.gov/NationalProvIdentStand/04_education.asp#TopOfPage on the CMS NPI web page and find the "NPI Training Package" under the "Downloads".

Providers who submit claims to CMDP can now submit their NPI number to the CMDP Provider Services Department . To submit the NPI number, providers can mail or fax a copy of their NPI notification to:

Comprehensive Medical and Dental Program
Attention: Provider Services
4000 N. Central Avenue, 22nd Floor
Phoenix, AZ 85038
Fax: 602-264-3801

The documentation must include the provider's name, AHCCCS ID number and provider's signature. NPI numbers will also be accepted via written notification either by mailing or faxing to the information listed previously.

After May 22,2007 for claims submission providers should use their NPI number. CMDP will accept both AHCCS ID and/or the NPI until January 1, 2008. More information is available at http://www.cms.hhs.gov/NationalProvIdentStand/. For questions please contact CMDP Provider Services at (602) 351-2245 Ext. 13770.



FOR ALL PROVIDERS

One of CMDP's Performance Improvement Projects measures how many developmental screenings and behavioral health screenings are being performed and documented. These screenings are requirements of an EPSDT visit. When performing an EPSDT assessment on your patient it is imperative that you document all age appropriate screenings that are performed, specifically, developmental and behavioral health screenings. You may in fact be assessing them, but unless you mark the appropriate box on the EPSDT form, you will not get credit for performing the assessment. We urge you to be diligent in documenting your work.

The American Academy of Pediatrics is calling for pediatricians to:

- **Ask parents questions about their children's development and look for signs of trouble at every well-child visit up to age 3.**
- **Use formal, proven developmental screening tests at 9 months, 18 months and again at either 24 or 30 months.**
- **Screen every child for autism at 18 months.**
- **Offer additional, formal screening any time a parent or doctor becomes concerned about a child.**
- **Refer children who fail screening tests to public early-intervention programs and to specialists who can evaluate the child fully, both for developmental disorders and related medical problems.**

Please be aware that you may **not** use the EPSDT form for "sick child" visits or visits other than an actual EPSDT visit. **You may not bill** for an EPSDT visit unless the **complete exam and all of the screenings have been performed** including behavioral health and developmental screens. EPSDT rates will not be paid for any other type of visit.

Thank you in advance for your cooperation in this matter and as always we look forward to working with you to provide the best care possible for our CMDP kids.

AAP Recommendations for Hepatitis A and Varicella

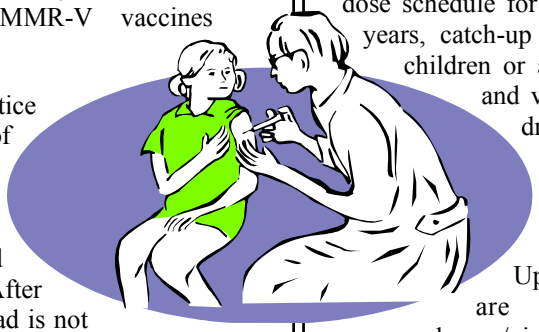
The AAP is recommending that all children receive a hepatitis A vaccine starting at 1 year of age (12 –23 months) and given as a 2-dose regimen. The 2-dose series should be administered at least 6 months apart.

The AAP also now recommends a 2-dose varicella immunization strategy. Children 12 months through 12 years of age should receive two 0.5 ml doses of varicella vaccine separated by at least 3 months. Children 13 years of age or older without evidence of immunity should receive two 0.5 ml doses of varicella vaccine separated by at least 28 days.

Update on Supply of Vaccines Containing Varicella-Zoster

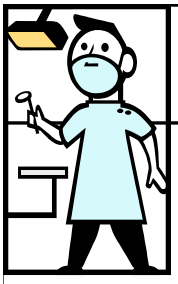
In February 2007, CDC received notice from Merck & Co., Inc., that because of lower than expected amounts of varicella-zoster virus (VZV) in its recently manufactured bulk vaccine, Merck was prioritizing production of varicella (Varivax®) and zoster vaccines (Zostavax®) over production of MMR-V vaccines (ProQuad®).

In May 2007, CDC received further notice from Merck that current projections of orders indicate ProQuad will be unavailable beginning in July 2007, although timing will depend on market demand. This might cause extended back orders for the next few months. After depletion of the existing supply ProQuad is not expected to be available for the remainder of 2007. Merck is requesting that customers begin transitioning from ProQuad to M-M-R II® and Varivax at their earliest convenience.



Merck expects to continue to meet demands for M-M-R II and Varivax to fully implement the recommended immunization schedule. This will allow for continued use of varicella vaccine for all age groups, including the routine 2-dose schedule for children aged 12--15 months and 4--6 years, catch-up vaccination with the second dose for children or adolescents who received only 1 dose, and vaccination with 2 doses for other children, adolescents and adults without evidence of immunity. Understand that this is **not** a supply issue but only a formulation issue.

Updates on vaccine shortages and delays are available from CDC at http://www.cdc.gov/nip/news/shortages/default.htm or thru their VFC representative.



DR. C says…….. By Dr. Jerry Caniglia, Dental Consultant

"Maximum Protection for High Risk Individuals: Professionally Applied Fluoride"

All persons should drink water with optimal fluoride concentration as well as brush their teeth with fluoridated toothpaste. But for those individuals who are at high risk for dental decay, additional fluoride measure might be needed.

To have effective caries prevention, identifying and assessing individuals at risk for developing new carious lesions is essential. Although there are various methods for determining risk, no one particular model predominates. Individuals believed to be at increased risk for dental caries are generally those from low income populations, those who lack dental education and those who are unable to access regular dental services. The lack of dental insurance, private or public, plays a critical role in access to care. Professionally applied topical fluorides, which contain a high concentration of fluoride compounds, have been applied by dentists and dental hygienists for over 50 years in the United States. These in-office fluorides and fluoride supplements should be prescribed to only those individuals at high-risk of developing caries, regardless of age. The most commonly used professionally applied topical agents are fluoride varnish, fluoride gel or foam, and in-office fluoride rinses. Research suggests that fluoride varnish and gel are equally effective in caries prevention. However, the risk of ingestion is less with a fluoride varnish and for this reason the varnish is preferable over the gel in children less than 6 years of age.

Fluoride continues to be the professional's best tool for the primary prevention of dental caries. Using topical fluoride products in an appropriate manner will significantly provide maximum protection, decrease the caries experience and improve the oral health of our communities.

Required Immunizations and EPSDT

There is a critical situation happening surrounding the health-care of our foster children. Based on numbers received from internal data, **63% of CMDP children are receiving the required immunizations and EPSDT visits within the first 24 months of life.** This period of life is critical in the health and well-being of our children.

By 24 months of age, the child should have received:

10 EPSDT Evaluations:

- 2-4 days
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months

26 Immunizations by 24 months of age:

- 3 Hepatitis B
- 4 DtaP
- 4 Hib
- 3 IPV
- 1 MMR
- 1 Varicella
- 4 Pneumococcal
- Yearly Influenza after 6 months of age
- 2 Hepatitis A
- 3 Rotavirus

Meeting the health care needs of children is a responsibility shared among parents, case managers, out-of-home care providers **and medical providers**. It is imperative that at every opportunity, a child's immunization status is evaluated. Health care professionals and parents often misunderstand contraindications to immunizations. Common conditions or circumstances that are **not contraindications** include but are not limited to:

- Mild acute illness with low-grade fever or mild diarrhea illness in an otherwise well child. Minor illness with or without fever does not contraindicate immunization. Fever, in itself, is not a contraindication to immunization.
- The convalescent phase of illness.
- Currently receiving antibiotic therapy.
- Reaction to a previous DTaP or DTP dose that involved only soreness, redness, or swelling in the immediate vicinity of the immunization site or temperature of less than 105°F.
- Prematurity—the appropriate age for initiating most immunizations in the prematurely born infant is the usually recommended chronologic age; vaccine doses should **not** be reduced for preterm infants.

Please be sure that infants and toddlers in foster care receive all the required immunizations and EPSDT visits listed above!

As the medical provider if you have a foster parent refuse immunizations, please contact the Medical Services Unit of CMDP for assistance.

U.S. Food and Drug Administration Center for Drug Evaluation and Research CMDP P&T meeting Update

Drug Withdrawals:
March 30, 2007: The FDA requested Novartis voluntarily discontinue marketing of the GI drug Zelnorm (tegaserod) due to serious heart problems. Novartis has agreed to voluntarily suspend marketing of Zelnorm in the United States. Zelnorm is used primarily to treat women with constipation predominant irritable bowel syndrome.

March 29, 2007: The FDA announced that manufacturers of pergolide (Permax) drug products, used to treat Parkinson's disease, will voluntarily remove these drugs from the market due to the risk of serious damage to patients' heart valves. Pergolide is in a class of medications called dopamine agonists. There are three other dopamine agonists that are not tied to valvular heart disease.

Black Box Warnings:
March 9, 2007: The FDA issued a public health advisory outlining new safety information, and revised labeling including a new boxed warning and modifications to the dosing instructions for erythropoiesis-stimulating agents (ESAs), widely used drugs for anemia. The drugs affected by the safety update are darbepoetin alfa (Aranesp) and epoetin alfa (Epogen and Procrit). The new warning advised physicians to monitor red blood cell levels (hemoglobin) and to adjust doses to maintain the lowest hemoglobin level needed to avoid blood transfusions. Recent studies have shown an increased risk of death, blood clots, strokes and heart attacks in patients with chronic kidney failure when ESAs were given at higher than recommended doses. In other studies, tumors grew faster in patients with head and neck cancer receiving higher doses.

February 21, 2007: The FDA requested Genentech to add a boxed warning to omalizumab (Xolair) that when used to treat patients with asthma related to allergies, it may cause anaphylaxis or a condition where the patient has trouble breathing, chest tightness, dizziness, and/or swelling of the mouth and throat. In addition, the FDA has asked Genentech to revise the label and provide a Medication guide for patients to strengthen the existing warning for anaphylaxis. Xolair was approved in 2003 to treat patients 12 years and above with moderate to severe persistent asthma who have tested positive for a perennial allergen such as pollen, grass or dust whose symptoms have not been controlled with inhaled steroids.

February 12, 2007: The FDA announced revisions to the labeling for Ketek (telithromycin) including the removal of 2 of the 3 indications (acute bacterial sinusitis and acute bacterial exacerbations of chronic bronchitis). It will remain on the market for the treatment of pneumonia of mild to moderate severity. There will also be a black box warning that Ketek is contraindicated in myasthenia gravis. The medication can cause visual disturbances, loss of consciousness and liver damage.

Other FDA News:
March 16, 2007: The FDA issued an alert regarding safety concerns for Zyvox (linezolid), an antibiotic. Certain patients (those with gram positive and gram negative infections or those infected with gram negative infections alone) taking the medication had a higher death rate than patients taking other antibiotics.

March 14, 2007: The FDA requested all manufacturers of sedative hypnotic drugs to update the labeling to include stronger language regarding risks such as severe allergic reactions and complex sleep-releated behaviors such as sleep driving. Examples of drugs included are Ambien, Sonata, Dalmane, Halcion, Prosom, Lunesta and others.

February 21, 2007: The FDA directed manufacturers of ADHD drugs to develop medication guides to alert patients of cardiovascular risks (stroke, increased blood pressure, heart attack) and the risks of adverse psychiatric symptoms (new or worse bipolar illness, aggression, hostility, hearing voices, or new manic symptoms) when taking the medications. Medications include Adderall/XR, methylphenidate, Strattera, and dexmethylphenidate.

January 29, 2007: The FDA approved first time generic dexmethylphenidate (generic Focalin) to treat ADHD.

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Performance Improvement Projects

Performance Improvement Projects or PIPs are studies that the health plans are mandated to perform for AHCCCS. Every year the health plan must conduct a study that is chosen by AHCCCS and a second study that is chosen by the health plan. The studies are designed to improve the health plans' performance in identified areas of risk. The ultimate goal being improved services for our members and comprehensive documentation of services by our providers.

Providers, CMDP needs your help with interventions for our Performance Improvement Projects or PIPs as they are referred to. Here is a brief overview of two of the PIPs and how you can help.

Improve Quality and Completeness of the EPSDT Visit
The decision to focus on the quality of the EPSDT visits for children who are CMDP members is based upon the importance of a complete EPSDT visit and meeting the needs and well being issues of the special needs population served by CMDP. Routine review of EPSDT forms reveals a lack of compliance in completing and documenting Developmental and Behavioral Health Assessments.

As a provider you are key to the successful conclusion of this PIP. **CMDP is asking all providers to be sure to perform age-appropriate Developmental and Behavioral Health assessments on CMDP members and to be sure to DOCUMENT that you have done so on the EPSDT forms.** Unfortunately, many of you are not getting credit for doing these assessments because you are not documenting that they have been performed, so please be diligent in documenting the work that you do.
This PIP will have ongoing reviews of all EPSDT forms being performed. CMDP will continue to contact non-compliant providers to remind them of the need to perform and document these assessments.

Study of Inappropriate ER Utilization
Routine review of the ER visit records reveals a lack of compliance in seeking out the care of the PCP and thus utilizing the ER as a source of primary care. This includes well child visits and immunizations. When members go to the ER for routine care, it undermines the continuity of their care. We need you, as the Primary Care Physician, to encourage members to come to your office for routine care, and to use the Emergency Room only during the hours that your office is not open or available and only for true emergency care.

CMDP wants to provide the best care possible for our members and we need you to accomplish this goal. Your assistance is vital to meeting the ongoing needs of our members and to meeting the goals of the ER Inappropriate Utilization PIP. This is a three-year project and CMDP will be contacting physicians regarding those members who are using the Emergency Rooms inappropriately. We will then depend upon your intervention with the member to redirect them to your office for their care needs.

Each year CMDP will be adding additional PIPs and we will keep you apprised of what they are and how your expertise will play a role in their implementation and resolution.
Thank you for your continued concern and care of CMDP's

ASIIS IS THE LAW!

CMDP needs your help in keeping the ASIIS system updated. The ASIIS system as you know is the statewide immunization records keeping system. According to the Arizona Revised Statute 36-135 it is mandated that all physicians record immunizations given to all children ages "birth through 18 years" in the ASIIS system. This only takes a few minutes and can prevent a child from being needlessly re-immunized because his/her immunization history is not known. This is particularly true of CMDP's population of foster children who may have frequent placement changes. Due to this their immunization records may not always accompany them. ASIIS is often the only way we can track records on these children.

ASIIS can be of great help to you in your practice. Not only can you find out about the immunization histories of your patients, but you can also print out forecasts of what immunizations are due and the time frame in which they need to be given. These can be given to the children's parents or guardians who can then partner with you in making sure their children are immunized. In addition to the regular immunizations, you can also track flu, pneumonia, PPD testing and results and much more. It is a user-friendly system and available to every physician's office.
Also, when you are entering a new record on a foster child please put "DES" for the name of the parent/responsible party and CMDP for the name of the Health Plan. For the phone number, use (602) 351-2245. This helps to prevent duplication of records when the foster parent's name changes. If you do find a duplication of records, please contact Richard Bradley with ASIIS at: bradler@azdhs.gov
CMDP cannot emphasize enough the importance of keeping the ASIIS system updated. If you do not have access to the ASIIS, need a sign-on or training, contact Richard Bradley at the above e-mail address. CMDP is depending on you to partner with us in keeping our children's immunizations up-to-date and CMDP thanks you for all of your efforts in helping us keep our children healthy.

Culturally Competent Care

The following are successful practices in delivering Culturally Competent Care:
1) Define culture broadly;
2) Value clients' cultural beliefs;
3) Recognize complexity in language interpretation;
4) Facilitate learning between providers and communities;
5) Involve the community in defining and addressing ser vice needs;
6) Collaborate with other agencies;
7) Professionalize staff hiring and training; and
8) Institutionalize cultural competence.

♦ Define Culture Broadly

Most people understand culture in its broadest sense and usually interpret it as something that groups possess. But health care is generally dispensed to individuals and there are other things in addition to race, language,and ethnicity that contribute to a person's sense of self in relation to others.
More specific or more general cultural subcategories are based on shared attributes (such as gender or sexual orientation), or shared life experiences (such as survival of violence and/or trauma, education, occupation or homelessness).
It is the convergence of multiple memberships in various cultural and sub cultural groups that contribute to an individual's personal identity and sense of their own "culture". Understanding how these factors affect how a person seeks and uses medical care, as well as their culture group's historical relationship to the medical establishment, is an integral part of providing culturally competent care.

♦ Value Clients' Cultural Beliefs

Another way in which cultural competence is demonstrated is the extent to which a provider is able to learn about and value its target community's knowledge, attitudes and beliefs about health care. Competence is also reflected in the extent to which that information is applied to improve access to and quality of care while respecting cultural health beliefs and practices.
In order to communicate effectively with clients, providers need to understand how to talk about sensitive issues such as sexuality, drug use and personal violence, among others. In many cases the provider must be willing to explore the individual life experiences of a client to find the underlying causes of their behaviors which may not be readily apparent.

♦ Recognize Complexity in Language Interpretation

Being able to speak a client's language is essential but it does not always guarantee effective communication between the client and the provider. Communication is more than simply shared language; it must also include a shared understanding and a shared context as well.
There are three overarching concepts to consider when providing culturally and linguistically appropriate health care:

- Recognizing the linguistic variation within a cultural group;
- Recognizing the cultural variation within a language group; and
- Recognizing the variation in literacy levels in all language groups.

♦ Facilitate Learning Between Providers and Communities

Creating environments where learning can occur is crucial to improving the health of both individuals and communities. Health care providers need to learn more about the cultural context, knowledge, beliefs and attitudes of the communities they serve. Communities need to learn more about how the health care delivery system works. Both need to learn how collaboration between providers and communities will improve access and quality of care through improved cultural competence.

Cultural competence means more than client satisfaction with services that only minimally meet the cultural or linguistic needs of the target community. True cultural competency involves clients and community members in identifying community needs, assets and barriers. In this approach, clients and community members play an active role in needs assessment, implementation and evaluation. Some organizations institutionalize this relationship by making individuals from the community voting members of their governing boards. Others ensure input and recommendations by using community advisory boards, client panels, task forces or town meetings. Still others sponsor locally based community research (interviews, focus groups, etc) and integrate the results into program design.
Some organizations also integrate clients and community members into programs by using volunteers from the target community in a variety of program areas serving as peer advocates who help new clients negotiate the system. Most of the nominated programs also try to hire individuals from the community or from cultural, economic and linguistic backgrounds that complement those of community members.

♦ Professionalize Staff Hiring and Training

- Establishing specific hiring qualifications and by mandated training requirements for all staff in language, medical interpretation and cultural competence as their positions necessitate;
- Producing a comprehensive and replicable training curriculum and qualifying factors; and
- Allocating the budget and time for staff training including training for new staff, annual updates and review, as well as testing and job application criteria.

Approach training in cultural competence and medical interpretation with the same seriousness as training in other essential clinical skills.

♦ Institutionalize Cultural Competence

1. making it an integral part of strategic planning at all levels;
2. making staffing and activities for cultural competence an integral piece of a sustainable funding stream; and
3. designing cultural competence activities with replicability in mind (both for other cultural groups and for other health care programs).

Critical to the long-term survival of culturally competent service delivery is sustainable funding for staff, training and other essential activities.

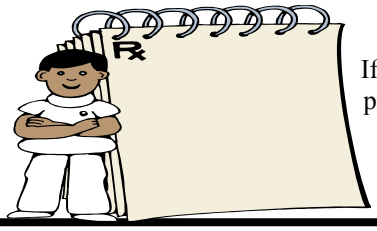
Billing PEDS (Parent's Evaluation of Developmental Status) Tool

To begin billing for the Developmental Screening using the PEDS (Parent's Evaluation of Developmental Status) Tool, the provider must complete training at www.azaap.org under the PEDS heading. This will trigger AzAAP to alert AHCCCS and the AHCCCS health plans that you have completed the training.

Use code 96110 with an EP Modifier.

The PEDS Interpretation and the PEDS Score forms need to be submitted with the claim for processing. Claims will be denied if the forms are not attached when processing the claim.

Prescription Troubles?



If a CMDP member states that they have experienced or are experiencing issues getting their prescriptions filled, please contact CMDP Member Services at (602) 351-2245 for assistance.

Just a Click Away!!!

You can now check CMDP's Claims Status or Member Eligibility on Line at the CMDP/DES website,

www.azdes.gov

or

www.azdes.gov/dcyf/cmpde.

You will need the Member's CMDP ID number, your AHCCCS Provider ID number and the Dates of Service you are verifying eligibility.

Once you have logged into the web site:

- Click **MEDICAL** (Left side of screen) for a drop-down menu
- Click on **Comprehensive Medical and Dental**. This will bring you to the CMDP website.
- Click PROVIDER SERVICES (Left side of screen).
- From here it gives you the option to choose either the Claims Lookup or the Members Lookup.
- Once you have selected either one of these options follow the step-by-step directions.

You can also verify eligibility via e-mail.

Member Services e-mail addresses:

MariaVillanueva@azdes.gov
LMoore@azdes.gov
RosemaryCelaya@azdes.gov

For further assistance with either member eligibility or claims status, please contact the Member Service Unit. If you need assistance with claims, please contact the Claims Unit. For general information in navigating through these systems, please contact your Provider Representative. All three of these units can be reached at (602) 351-2245 or (800) 201-1795.

New Deadline for Required Submission of the Form CMS-1500 (08-05)

The CMS-1500 answers the needs of many health insurers. It is the paper claim form prescribed by CMS for use by physicians and suppliers that qualify for an exemption from the mandatory electronic claims submission requirements. CMS (Centers for Medicare and Medicaid Services) released the Form CMS-1500 (08-05) with an implementation date of July 2, 2007. Due to the short notice, CMDP will use the implementation date of October 1, 2007, which complies with the AHCCCS' implementation date. Therefore, effective 10-1-**07** providers are required to submit all claims on the CMS -1500 (08-05) Form in accordance with the CMS regulations. Any claims submitted on or after 10/1/07 on the incorrect Form will be denied. If you have any questions, please contact Provider Services Department.

CMDP Contacts:
(602) 351-2245
(800) 201-1795

MEMBER SERVICES:
To verify a member's eligibility, choose any of these options:
****Please have member's name, date of birth, date of service & ID #.**
CMDP offers our providers eligibility verification via

- Phone (602) 351-2245, (800) 201-1795
- FAX (602) 264-3801
- Internet Website: www.azdes.gov/dcyf/cmdpe

Phone: Option 1 for English, Option 2 –if you are calling from a providers office, then Option 1

PROVIDER SERVICES:
Option 1, Option 2, then Option 3
For all your concerns, Provider Services will assist you or direct you to the appropriate department.

CLAIMS:
Option 1, Option 2 then Option 2
For verification of claim status, please select the options listed above for a claims representative.

CLAIMS MAILING ADDRESS:
CMDP 942-C, PO BOX 29202, PHOENIX, AZ 85038-9202

MEDICAL SERVICES:
Option 1, Option 2 then :

Hospitalizations…..Option 7

Prior Authorizations:

Medical…….Option 5
Dental……...Option 4
Pharmacy…..Option 8
Behavioral Health...Option 6
Please contact Medical Services with any questions regarding the medical needs of our members.

"Web Corner"

The following is a list of websites we recommend to assist your office. If there are any other websites you wish to add and share with other providers please contact Provider Services. We will add them to our next newsletter.

CMDP's Website: www.azdes.gov/dcyf/cmdpe

Your location for an updated:

- Provider Manual
- Newsletters
- Member Handbook
- Preferred Medication List (PML)
- Forms
- Provider Directory
- Member Eligibility Verification
- Claims Status

UPDATED CAP FEE SCHEDULE, **AHCCCS Provider Manual** , EPSDT forms and more available at: www.azahcccs.gov

CHILDREN'S REHABILITATIVE SERVICES (CRS), information and referral forms: www.hs.state.az.us/phs/ocshcn/crs/index.htm

VACCINES FOR CHILDREN (VFC) Program: www.cdc.gov/nip/vfc/Provider/ProvidersHomePage.htm

Every Child by Two Immunizations: www.ecbt.org

ASIIS and TAPI: www.whyimmunize.org/us.htm

American Academy of Pediatrics: www.aap.org

COMPREHENSIVE MEDICAL & DENTAL PROGRAM

Equal Opportunity Employer/Program. This document available in alternative formats by contacting Provider Services.